

**DISABLED VETERANS APPLICATION FOR VOCATIONAL REHABILITATION***(Chapter 31 - Title 38, U.S.C.)*PAYEE  
NO.

TRANS CODE

**IMPORTANT:** Please read information on reverse before completing this form. TYPE OR PRINT IN INK.**1. SERVICES AND ASSISTANCE NEEDED** *(Check all that apply)*

- ☐ I WANT TO GO TO COLLEGE OR VOCATIONAL SCHOOL  
☐ I WANT AN APPRENTICESHIP OR OTHER ON-JOB TRAINING SCHOOL  
☐ I WANT TO BECOME MORE INDEPENDENT IN DAILY LIVING  
☐ I NEED HELP IN GETTING A JOB  
☐ I AM NOT SURE, BUT I WANT TO SEE WHAT VA HAS AVAILABLE

**2. FIRST, MIDDLE, LAST NAME OF VETERAN****3. SOCIAL SECURITY NO.****4. VA FILE NO.****5. MAILING ADDRESS** *(No. and street or rural route, city, State, and ZIP Code)***6. HOME TELEPHONE NO.** *(Include Area Code)***7. WORK TELEPHONE NO.** *(Include Area Code)***8. DATE OF BIRTH****9. VA OFFICE WHERE RECORDS ARE LOCATED** *(If known)***10. PERMANENT ADDRESS** *(If different than Item 5)***11. SEX**☐ MALE ☐ FEMALE**12. SERVICE INFORMATION** *(Enter the following information for each period of active duty. Show ALL active duty)*

SERVICE NUMBER <i>(Prefix and suffix)</i> (A)	BRANCH OF SERVICE (B)	DATE ENTERED ACTIVE DUTY (C)	DATE SEPARATED FROM ACTIVE DUTY (D)	TYPE OF SEPARATION OR DISCHARGE (E)	GRADE OR RANK AT SEPARATION OR DISCHARGE (F)

**13. IF NOW HOSPITALIZED, GIVE NAME AND LOCATION OF HOSPITAL**(DO NOT WRITE IN THIS SPACE)  
(VA DATE STAMP)**14. VA BENEFITS PREVIOUSLY APPLIED FOR**

- ☐ A. HOSPITALIZATION OR MEDICAL CARE  
☐ B. WAIVER OF NSLI PREMIUM  
☐ C. DENTAL OR OUTPATIENT TREATMENT  
☐ D. VOCATIONAL REHABILITATION *(Chapter 31)*  
☐ E. VETERANS' EDUCATIONAL ASSISTANCE *(Chp. 30, 32, 33, or 34)*  
☐ F. WAR ORPHANS' OR DEPENDENTS' EDUCATIONAL ASSIST. *(Chp. 35)*  
☐ G. PENSION  
☐ H. SERVICE-CONNECTED DISABILITY COMPENSATION *(If receiving compensation, complete Items 14L and 14M)*  
☐ I. VOCATIONAL TRAINING FOR VA PENSIONERS *(Chapter 15)*  
☐ J. MONTGOMERY GI BILL SELECTED RESERVE  
☐ K. NONE  
☐ L. OTHER *(Specify)*

**COMPLETE ONLY IF ITEM 14H IS CHECKED****L. VA DISABILITY RATING**

%

**M. NATURE OF DISABILITY****15. DEPENDENTS** *(Check applicable boxes. If VA authorizes training, you may have to submit documentary evidence before additional subsistence allowance benefits for dependents may begin)*

- ☐ NONE ☐ SPOUSE ☐ CHILDREN *(Specify No.)* ☐ PARENTS DEPENDENT ON YOU FOR SUPPORT *(Specify No.)*

**16. EDUCATIONAL LEVEL** *(Indicates the highest level completed)*

- ☐ LESS THAN HIGH SCHOOL DIPLOMA *(Specify last grade level)* ☐ HIGH SCHOOL DIPLOMA/GED ☐ COLLEGE *(Specify years completed)* ☐ GRADUATE DEGREE

**17. PREVIOUS NON-VA REHABILITATION SERVICES****HAVE YOU RECEIVED VOCATIONAL REHABILITATION SERVICES FROM AGENCIES OTHER THAN VA?**

- ☐ YES ☐ NO *(If "Yes," name each agency which provided service, the types of services provided, and the beginning and ending dates when you received the services)*

I HEREBY CERTIFY THAT all the information I have entered on this form is true and complete to the best of my knowledge and belief and I realize that making willful false statements concerning a material fact in a claim for vocational rehabilitation benefits is a punishable offense which may result in fine or imprisonment or both.

**18A. SIGNATURE OF APPLICANT** *(Do not print) (Sign in ink)***18B. DATE****19. AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize release of school, employment and other records to VA for use in counseling me and supervising my rehabilitation program. I also authorize VA to release to schools, other training establishments, job placement or related agencies, and to potential employers any information, to include my name and address, which will assist me in my vocational rehabilitation program or in my search for gainful employment.

**A. SIGNATURE OF APPLICANT** *(Do not print) (Sign in ink)***B. DATE**

FOR VA USE ONLY

DEP

ED. LEVEL

CLAIM STATUS

DATE REFERRED VR&amp;C